

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 009443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2013
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of two (2) State complaints.</p> <p>Date of survey: 11-18-13 through 11-19-13</p> <p>Facility number: 009443</p> <p>Complaint numbers: IN00138251 Unsubstantiated; No deficiencies cited; Lack of sufficient evidence. IN00138707 Unsubstantiated; No deficiencies cited; Lack of sufficient evidence.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Select Specialty is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 12/05/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE